REQUEST TO INCREASE HEALTH CARE STABILIZATION FUND COVERAGE LIMITS

ANY HEALTH CARE PROVIDER WISHING TO INCREASE THEIR PREVIOUSLY SELECTED HEALTH CARE STABILIZATION FUND COVERAGE LIMITS MUST COMPLETE THIS FORM AND SUBMIT IT TO THE FUND OFFICE BY FACSIMILE OR U.S. MAIL (ADDRESSES ARE SHOWN AT THE BOTTOM OF THIS FORM).

Section I - Health Care Provider Information

A. Your Full Name: _____ (LAST NAME or ENTITY NAME), _____ (FIRST NAME), _____ (MIDDLE INITIAL)

B. Residence Address: _____ (LEGAL RESIDENT ADDRESS) Telephone No.: _____

C. City, State and Zip Code: _____ (CITY), _____ (STATE), _____ (ZIP CODE)

D. Your Health Care Provider Professional Designation (M.D., D.O., RNA, Hospital, etc): _____

E. Your Health Care Provider License, Registration or Certification Number: _____

F. Name Of Your Insurance Company: _____

G. Name Of Your Insurance Agent: _____

Section II - Request Increase In My Existing Health Care Stabilization Fund Coverage Limits

A. My **PRESENT** Fund coverage limits are: $100,000/$300,000 ***OR*** $300,000/$900,000

B. I am requesting the **HIGHER** Fund coverage limits of: $300,000/$900,000 ***OR*** $800,000/$2,400,000

C. I am requesting this increase in Fund coverage limits for the following reason(s) (if necessary use additional paper):

_____

_____

_____

D. I am requesting that the higher limits be made effective on:

☐ Date request received (pending Board approval).

OR ☐ Date of next renewal, which is: _____ (MONTH), _____ (DATE), _____ (YEAR).

E. I understand that the higher Fund coverage limits will not become effective until my request is approved by the Fund Board of Governors. I also understand that changes in Fund coverage apply only to incidents which occur after the effective date of Board approval.

F. Upon notification by the Fund Board of Governors I will pay any additional surcharge payment for the higher Fund coverage limits I have requested within thirty days of the effective date of the requested higher Fund coverage limits.

_____ **DATE SIGNED**

_____ **SIGNATURE OF HEALTH CARE PROVIDER -- REQUIRED**

HEALTH CARE STABILIZATION FUND OFFICE ADDRESS: 300 SW 8TH AVENUE, 2ND FLOOR, TOPEKA, KANSAS 66603
TELEPHONE: 785-291-3777 FACSIMILE: 785-291-3550 E-MAIL: hcsf@hcsf.org